
For debate

Psychiatric diagnosis, psychiatric power and psychiatric abuse

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Author's abstract

Psychiatric abuse, such as we usually associate with practices in the former Soviet Union, is related not to the misuse of psychiatric diagnoses, but to the political power intrinsic to the social role of the psychiatrist in totalitarian and democratic societies alike. Some reflections are offered on the modern, therapeutic state's proclivity to treat adults as patients rather than citizens, disjoin rights from responsibilities, and thus corrupt the language of political-philosophical discourse.

'Power tends to corrupt; absolute power corrupts absolutely.'

Lord Acton (1)

The massive and steadily growing literature on the so called political abuses of psychiatry – especially in the former Soviet Union – threatens to obscure the fact that it is psychiatric power, not psychiatric diagnosis, that makes the political abuse of psychiatry not merely possible but inevitable (2).

The misleading focus on psychiatric diagnosis is illustrated by the essay, 'Concepts of disease and the abuse of psychiatry in the USSR,' (3). The authors write:

'There is a strong *prima facie* case linking the abuse of psychiatry with difficulties about the concept of mental illness. ... However, a survey of recent Soviet literature showed that the concept of disease employed in the former USSR (where abuse was for a time widespread) was similar to its counterpart in the UK and USA in being strongly scientific in nature.'

These sentences imply that a more truly scientific classification of mental illnesses (or persons or [mis]behaviours) would hinder the abuse of psychiatry. However, as the authors themselves later make clear, and as Fulford (4) spells out in detail in his book, a scientific classification is not sufficient to protect from abuse. The classification by slave

traders and slave owners of certain persons as Negroes was scientific, in the sense that whites were rarely classified as blacks. But that did not prevent the 'abuse' of such racial classification, because (what we call) its abuse was, in fact, its use.

Divorcing concept from consequence

Psychiatric practice, as the term implies, is a practical, not a theoretical, enterprise. Accordingly, so long as psychiatrists continue to assign the role of mental patient to persons against their will, that fact will remain a fundamental characteristic of psychiatric practice. Before abandoning psychiatry for philosophy, Karl Jaspers called attention to this issue. He wrote:

'Admission to hospital often takes place against the will of the patient and therefore the psychiatrist finds himself in a different relation to his patient than other doctors. He tries to make this difference as negligible as possible by deliberately emphasizing his purely medical approach to the patient, but the latter in many cases is quite convinced that he is well and resists these medical efforts' (5).

Although this situation has not changed since 1913, when *General Psychopathology* was first published, psychiatrists are now less willing than were Jaspers's colleagues to recognize that they are agents of state-sanctioned coercion. While this denial has been carried furthest in totalitarian countries, where all physicians (and many non-physicians as well) were agents of state-sanctioned coercion, the same denial is clearly manifest in Western – perhaps especially American – psychiatry as well. For example, in a lead essay in a recent issue of *Psychiatric News*, Herbert S Gross, MD declares:

'We need to lobby for the power to detain and treat the mentally ill involuntarily, including the homeless mentally ill. We may not regain the power we once had – and in some cases abused – but lobbying for a *fair way to help* recalcitrant psychotics to help themselves is right; and lobbying for what is right advances psychiatry's credibility' (6). (Emphasis added.)

Key words

Psychiatry; abuse of psychiatry; psychiatric patients.

Fulford *et al* correctly emphasize the subjective character of psychiatric classifications and the value-laden nature of psychiatric diagnoses, but fail to acknowledge the role of psychiatric power. They state:

'An important vulnerability factor, therefore, for the abuse of psychiatry, is the subjective nature of the observations on which psychiatric diagnosis currently depends' (3).

However, the crucial issue is not subjectivity versus objectivity, but coercion versus co-operation, wielding power versus not wielding power. Art historians, drama critics, musicologists, and many other scholars also make subjective classifications; however, lacking state-sanctioned power over persons, their classifications do not lead to anyone's being deprived of life, liberty, or property. Surely, the plastic surgeon's classification of beauty is subjective. But because the plastic surgeon cannot treat his or her patient without the patient's consent, there *cannot* be any political abuse of plastic surgery. It is as simple, and inconvenient, as that.

The preoccupation of Western psychiatrists with Soviet psychiatric abuses is, in my opinion, merely another symptom of a moral disorder endemic to all of psychiatry. As the title of the essay by Fulford *et al* indicates, the authors prejudge the nature of the problem by assuming that the abuse of psychiatry in the USSR was distinctively different from its abuse in the West or, for that matter, in National Socialist Germany or Czarist Russia. This premise is false. In addition, Western psychiatry's preoccupation with Soviet psychiatric abuses has obscured the distinction between abuses motivated and made possible by a combination of professional authority, human rapacity, and personal gullibility, and abuses motivated and made possible by political ideology, law, and the human need for conformity. The former type of abuse, as George Bernard Shaw observed in *The Doctor's Dilemma*, is endemic to the professions. 'All professions,' he observed, 'are conspiracies against the laity' (7). However, a physician in his private office can defraud a person only by first *persuading* him that he is sick when he is not, or if he is sick that he will profit from a worthless treatment, and so forth. This kind of abuse can occur only with the co-operation/collusion of the patient/client, and must be distinguished from the abuse of the victim (who is not a patient or client in the proper sense) by *force*, for which his co-operation is not required. Because the latter type of 'abuse' requires the deployment of state-sanctioned power, it is, by definition, not considered to be an abuse when and where it occurs.

In other words, the role of the psychiatrist as agent of the state resembles that of the policeman or prison guard. The policeman must arrest, and the warden must imprison, lawbreakers regardless of whether

the laws they violate are good or bad. Similarly, the psychiatrist must act in conformity with the mental health laws of his society. Overlooking this, Fulford *et al* conclude that 'specifically, as a vulnerability factor [for psychiatric abuse], the relatively underdeveloped state of psychiatric science is important' (3).

I should like to note here, however, that Fulford (8) recognizes the crucial role of power in psychiatric abuse and, indeed, emphasizes that the issue of power is 'inherent in *all* psychiatric treatment. In other words, *voluntary* psychiatric treatment is concessionary!' Why is this so? Because 'decisions about involuntary treatment turn (centrally though not exclusively) on the *psychiatrist's* assessment of the rationality of the patient' (8).*

Over the past 30 years, in a series of essays on psychiatry in the Soviet Union (9,10,11,12,13), and in comments scattered in my other writings (14,15), I have tried to show that the scientific or unscientific character of psychiatry has nothing to do with its abuse. This is because the *professional uses* and *political abuses* of psychiatry are tributaries of the same stream, called 'power'. I maintain that without psychiatric power there could be neither psychiatric abuse nor normal psychiatric practice, as we know it. If mental diseases truly were like other diseases; if the law truly treated mental diseases and mental patients like it treats bodily diseases and ordinary patients; and if psychiatrists truly were like other doctors, then psychiatric practice – like dermatological or ophthalmological practice – would have to be limited to consenting clients (and to children and adults declared legally incompetent). As a physician, the psychiatrist would still possess authority. Hence, like other physicians, he could abuse his professional role for *personal* economic or sexual gain; but, lacking power, he could not abuse psychiatry for *political* purposes.

Insanity, infantilism and psychiatric power

Finding the key to unlock the dilemma of psychiatric abuse is like finding the legendary drunk's house key. The drunkard does not look for his key where he dropped it, where it is dark, but under the street light, where he can see better. Similarly, we look for the causes of psychiatric abuses in concepts with which we are comfortable, rather than in coercion with which we are not. Yet if the professional use and political abuse of psychiatry both rest on wielding legitimate state power, that is where we must look for the solution of the problem of psychiatric abuse – provided we prefer finding it to looking for it.

The key to the problem of psychiatric abuse was dropped ages ago and, for a long time, it lay bathed

*I should like to thank Dr Fulford for this personal communication.

in broad daylight where it was easy to see. 'Over natural fools, children, or madmen, there is no law, no more than over brute beasts,' declared Thomas Hobbes (16). Even earlier, English law treated infants, idiots, and the insane as if they comprised a homogeneous group, characterized by the absence of the capacity for reasoning and self-control, rendering them unfit for participation in political society. Accordingly, they were deprived of the benefits of liberty and the burdens of responsibility were lifted from their shoulders. At the end of the seventeenth century, John Locke, himself a physician, put it thus:

'And so, Lunatics and Ideots are never set free from the Government of their Parents; Children, who are as yet not come unto those years whereat they may have; and Innocents which are excluded by a natural defect from ever having; Thirdly, Madmen, which for the present cannot possibly have the use of right Reason to guide themselves, have for their Guide, the Reason that guideth other Men which are Tutors over them' (17).

This cliché is still trotted out when needed, as if it solved the dilemma of the rights and responsibilities of mental patients. It does not. The differences between the coping skills of infants and the insane are obvious and become apparent during periods of great social upheaval. Deprived by death or abandonment of their caretakers, infants quickly perish, while most of the insane survive and often become indistinguishable from the sane. It is precisely the coping skills which infants lack but mental patients possess that now enable the latter to survive on the streets and disturb the social order.

Economics, politics and psychiatry

Psychiatrists differ from other physicians by virtue of the power they possess and wield over their patients; and mental patients typically differ from medical and surgical patients, by virtue of their economic dependency and social deviance. Neither phenomenon has received the attention it deserves.

There are three ways a person can obtain the necessities of life: 1) As a dependant, receiving food and shelter from donors (parents, family, church, state); 2) as a producer, providing for his own needs; or 3) as a predator, using force or the threat of force to rob others of the goods and services he needs or wants. An individual who does not want to be, or cannot be, a producer, must become a dependant or a predator or perish. Anything that discourages or prevents peaceful market relations among productive adults – regardless of whether it is due to biological, cultural, economic, or political factors – thus encourages dependency or predation or both. The fact that both are adaptive – that both

parasitism and crime 'pay' – accounts for the high incidence of both behaviour patterns in affluent societies and among members of the underclass. Also, because many of the people we call mentally ill engage in *de facto* predatory behaviour, and because many others use their dependency coercively in a quasi-predatory fashion, the supposedly mysterious connection between crime and mental illness turns out to be no mystery at all. It is simply the result of our penchant for attributing many predatory activities to mental illness.

The results of a NAMI (National Alliance for the Mentally Ill) survey of their membership support my contention about the relationship between (chronic) mental illness and dependency. Asked: 'What does your mentally ill relative do during the day?' respondents described 59 per cent of the patients as completely non-self-supporting, and 14 per cent as spending their days 'in a structured day-treatment programme' (18).

Minors and other dependants are human beings and belong in and to society. It is wicked to devalue, diminish, or destroy them. But it is absurd to value them more highly than the productive members of society. The legal and political framework of a free society, fit for adults, cannot be based on the needs of dependants and non-producers and on extrapolating from their proper relation to the state to the proper relations of independent adults to the state. Kenneth Minogue makes this point eloquently. He writes:

'The state is essentially an association of independent and resourceful individuals living under law and, from a political point of view, the poor and the needy are nothing less than a threat to our freedom. They are, for example, the materials of the demagogue, who tries to gain power by promising to use the coercive power of the state to redistribute benefits' (19).

Indeed, the state is not, and cannot be, an association of dependent individuals unable to live under law, because they cannot be held responsible for violating legal prohibitions. Minogue rightly emphasizes that the non-productive members of society pose a threat to liberty by virtue of their dependency and seducibility. Nor is that all. They threaten liberty also because the productive members of society have to take care of them as well as of their guardians. 'None of this,' Minogue cautions, 'is to deny that we have moral and perhaps political duties toward the poor ... [T]he essential point is that to take one's bearings on the nature of the state from the condition of the poor is to start off on the wrong foot. Citizens are categorically different from pensioners' (20). Citizens are also categorically different from dependants.

These reflections explain why, as the state increasingly treats adults as patients, the language of

traditional political philosophy atrophies, and instead we adopt the language of diagnosis and treatment for analyzing the relations of the citizen to the state. In turn, the abandonment of the perspective of political philosophy explains the pernicious disjoining of the mental patient's rights and responsibilities that has been the hallmark of modern mental health legislation. Illustrative of this phenomenon is the fact that the law treats both institutionalized and deinstitutionalized mental patients as competent to retain their right to vote, but not competent to be held responsible for violating the criminal law. 'The abuse of greatness,' Shakespeare remarks in *Julius Caesar*, 'is when it disjoins remorse from power' (21). Similarly, the abuse of power characteristic of the Therapeutic State is that it disjoins liberty from responsibility. Thus, when psychiatrists deprive innocent persons of freedom (civil commitment), they abuse the right to liberty; and when they excuse persons of crimes (diminished capacity and the insanity defence), they pervert the principle that persons are moral agents who should be held accountable for their actions.

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References

- (1) Acton. J E E D. Letter to Bishop Mandel Creighton: 1887 Apr 5. In: Bartlett J, ed. *Familiar quotations* [14th ed]. Boston: Little Brown, 1968: 750.
- (2) Szasz T S. Noncoercive psychiatry: an oxymoron. *Journal of humanistic psychology* 1992; 31: 117-125.
- (3) Fulford K W M, Smirnov A Y U, Snow E. Concepts of disease and the abuse of psychiatry in the USSR. *British journal of psychiatry* 1993; 162: 801-810.
- (4) Fulford K W M. *Moral theory and medical practice*. Cambridge: Cambridge University Press, 1989.
- (5) Jaspers K *General psychopathology* [7th ed]. Chicago: University of Chicago Press, 1946: 839-840.
- (6) Gross H S. Psychiatry needs ways to communicate. *Psychiatric news* 1993; 28: 13.
- (7) Shaw G B. *The doctor's dilemma*. Baltimore: Penguin, 1954: 16. First published 1913.
- (8) Fulford K W M. 1993 Sept 15: personal communication.
- (9) Szasz T S. Toward the therapeutic state. *New republic* 1965 Dec 11: 26-29.
- (10) Szasz T S. 'More cruel than the gas chamber'. *New society* 1971 Dec 16: 1213-1215.
- (11) Szasz T S. Soviet psychiatry: the historical background. *Inquiry* 1977 Dec 5: 4-5.
- (12) Szasz T S. Soviet psychiatry: its supporters in the West. *Inquiry* 1978 Jan 2: 4-5.
- (13) Szasz T S. Soviet psychiatry: winking at psychiatric terror. *Inquiry* 1987 Feb 6: 3-4. These five essays (9-13) are reprinted in Szasz T S. *The therapeutic state: psychiatry in the mirror of current events*. Buffalo, NY: Prometheus Books, 1984.
- (14) Szasz T S. *Insanity: the idea and its consequences*. New York: Wiley, 1987.
- (15) Szasz T S. *Law, liberty, and psychiatry*. Syracuse: Syracuse University Press, 1989.
- (16) Hobbes T. *Leviathan*. Edited by Oakeshott M. New York: Macmillan, 1962: 202. First published 1651.
- (17) Locke J. *The second treatise of government*, in *Two treatises of government*. New York: Mentor, 1960: 350. First published 1690.
- (18) National Alliance for the Mentally Ill. NAMI members on employment. *NAMI advocate* 1992; 13: 3.
- (19) Minogue K. Pisher's progress. *National review* 1989 Dec 31: 38.
- (20) See reference (19): 39.
- (21) Shakespeare W. *Julius Caesar* Act II, Sc 1, line 18.

News and notes

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